New Spaces for Health Promotion:

Opportunities & Challenges

June 2000

ISBN# 1-895992-98-2

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100-06646/

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This report is part of the Canada West Foundation's Canada-United States Health Study. The study was funded by the Donner Canadian Foundation (Grant B-05-98) and would not have been possible without its generous support. The authors wish to thank everyone that agreed to take time out of their busy schedules to be interviewed for the study. The authors also extend their thanks to Robert Roach for assistance with the layout and design of this document. For more information about the Canada-United States Health Study, please contact Dr. Roger Gibbins (rgibbins@cwf.ca).

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Table of Contents

I. Integrated Systems & Health Promotion: Theoretical Discussion 2

II. Rationale for the Study 4

III. Research Methods 6

IV. Towards Common Definitions & Goals 7

V. Needs of the System vs. the Needs of the Population 14

VI. Leadership & Partnerships 20

VII. Measuring Outcomes 28

VIII. Conclusion 33

Appendix 36

Notes 41

References 42

New Spaces for Health Promotion: Opportunities & Challenges

This study examines approaches to health promotion and disease prevention in two types of integrated health care organizations: (1) managed care[1] in San Diego, California, USA; and (2) regionalization[2] in Calgary, Alberta, Canada. Managed care exists throughout the United States, and regionalization exists in some form in each of the Canadian provinces with the exception of Ontario. For the purposes of this study, health promotion and disease prevention are examined through the perspectives of managers and providers rather than from the viewpoint of insurers, funders or clients of health care services.

Clearly, many parallel policies and corresponding change processes are developing across Canada and the United States, and within many health care systems across the globe. The intent of this study is to examine systematically opportunities and challenges in relation to preventing disease and promoting health in two very different systems of care.

Managed care organizations in San Diego and Regional Health Authorities in Alberta are examples of health care organizations with the common goals of cost containment and quality of care.

Managed care organizations (MCOs) in San Diego and Regional Health Authorities in Alberta are examples of health care organizations with the common goals of cost containment and quality of care. Lamb et al. (1991:4) note that managed care "involves planning, organizing and implementing a system in which the goals of health care can be realized." They include prevention of illness and promotion of health among the components of quality care.[3] Similarly, one of the key responsibilities of a regionalized system of care, as illustrated by Alberta's Regional Health Authorities Act (1994), is to "Promote and protect the health of the population in the health region and work towards the prevention of disease and injury."

While the differences between the two organizational structures are not the focus of this discussion, they should be noted. Differences include:

- competitive versus monopoly environments;
- geographic versus subscriber population bases;
- private versus public systems; and
- single payer versus pluralistic payers.

More specific distinctions regarding health promotion and disease prevention emerge from the case studies and are discussed throughout the report.

I. Integrated Systems & Health Promotion: Theoretical Discussion

Both managed care organizations and regional health authorities have at least an espoused impetus to promote health and provide prevention services. Whether or not this impetus translates into practice is a question of much debate and research. Before turning to the findings of this study, it is necessary to provide some theoretical background regarding the relationship between integrated systems, on the one hand, and health promotion and disease prevention, on the other.

Regionalization, Health Promotion & Disease Prevention

The relationship between regionalization, health promotion and disease prevention is not only one of legal impetus. As Casebeer, Scott and Hannah (1998:1) note, regionalization may engender

> further movement away from central provincial control of Alberta's health care system, opening the way for the potential development of more local strategic mechanisms for encouraging more community based service provision within and among regional health authorities.

Regionalization provides another platform for focusing health promotion and disease prevention on a population base.

Regionalization thus provides another platform for focusing health promotion and disease prevention on a population base. The roots of the inclusion of health promotion and disease prevention in the Regional Health Authorities Act (1994) can be traced in part to the Edmonton Board of Health's 1990 Strategic Plan which integrated health promotion and public health, and had the reduction of inequities in health as a focus (Kotani and Goldblatt, 1994). Kotani and Goldblatt emphasize that notions of health promotion and disease prevention have been part of the Alberta landscape since the 1960s but were addressed through Preventive Social Services rather than through Health (Bella, 1981), which became a separate Ministry only in 1988. The current legal impetus for health promotion and disease prevention comes from the 1994 Act.

Managed Care, Health Promotion & Disease Prevention

American policy development in health promotion and disease prevention takes its cue from Canadian experience (see the Appendix). There is a similar legal impetus for managed care organizations to deliver preventive services as the provision of health education and preventive services is required by enabling legislation, specifically Title XIII of the Public Health Services Act, PL 93-22 (Carlaw and DiAngelis, 1982). Beyond legal impetus, there are, in theory, economic incentives for managed care organizations to provide preventive

services. As Luft (1978:142) explains, "The general assumption is that preventive services and earlier treatment will catch a problem in its initial stages and eliminate the need for more expensive curative services at a later stage."

In a presentation to the "Prevention in Managed Care" conference in Atlanta, Mark Smith articulated the relationship between prevention and managed care. He underscored the promise of managed care as an opportunity to practice population health:

> For the first time, there is an entity with a *financial incentive* to do prevention. For the first time, there is an entity in whose best interest it is to do preventive medical care. There is a historical change that public health people are coming to grasp as the big advantage of managed care. (Smith, 1998:5)

He also stressed the organizational capacity of managed care to perform tasks such as partner notification and surveillance. Smith noted that public health and managed care have become linked because public health has been a leader in behavioural medicine, outreach and prevention, and managed care now has an interest in following its lead. In short, Smith suggests the following reasons why managed care organizations provide preventive care: (1) financial incentives; (2) organizational capacity; (3) they are population-based; and (4) they often serve populations other than the mainstream.

Surveillance of chronic diseases is an area in which managed care organizations might have both the financial incentive and organizational capacity to take action.

Another incentive for managed care organizations to provide preventive services is that they can be held accountable to do so by public health agencies (Harris, Caldwell and Cahill 1998:9). By the nature of their ability to collect data about their patients, public health agencies can monitor managed care performance and demand that they provide more preventive services. Both managed care organizations and public health agencies are information-intensive enterprises (Brook, McGlynn and Cleary, 1996:966-9). Further, Rutherford (1998:54) argues that managed care and public health should complement one another because they can both perform the following disease surveillance tasks: (1) disease reporting by clinicians and others; (2) laboratory-based disease reporting; (3) surveillance of behaviours associated with the acquisition and prevention of communicable diseases; and (4) surveillance of clinical preventive service delivery.

Surveillance of chronic diseases is one particular area in which managed care organizations might have both the financial incentive and organizational capacity to take action (Vinicor, 1998:87). Asthma and diabetes are chronic diseases for which education might contribute to positive outcomes. Diabetes especially is a disease where the long-term care costs are well-documented and where disease management has demonstrable positive effects on health.

However, while there are theoretical reasons to assume that managed care organizations are suited to deliver preventive and health promotion services, the literature suggests this theory rarely translates into practice. For example, Abelson and Lomas (1990:575) note that, "In general, the results of these studies have suggested only mediocre performance in the area of disease prevention." Moreover, Vogt, Kohatsu and Rutherford (1994: 63) point out that, "Although managed care organizations seem to have unique advantages for providing superior prevention and early detection services, these advantages are rarely realized."

Two reasons for this lack of success are outlined in the literature: disincentives for physicians and the nature of disease prevention programs. In an early discussion of prevention and HMOs, Harrington commented on the physician's dilemma: "If the physician is successful in keeping members happy, healthy and at home, new members are added to the open schedule. The result is that the physician who is successful in the objectives of the prepaid practice is penalized by a larger caseload" (in Carlaw and DiAngelis, 1982:86). As for the second reason, one of the barriers identified in a study of the effectiveness of health education was that at least one-third of patients will reject the medical advice they receive (Mullen and Zapka, 1981:296). Suggested remedies included education at every encounter with the physician to increase adherence.

The justification for this study was to capture an understanding of health promotion and disease prevention practice within two very different health care jurisdictions, and to share across borders what constitutes real and positive implementation of good practice.

In addition, Luft (1978:160) notes that preventive services are subject to cost constraints: "The financial costs of screening a large number of people can be substantial, especially when relatively few people have undiagnosed problems." In one study, opposition to health promotion was expressed by the belief that it is extremely expensive. As Cowley (1986:208) observes, "$100,000 spent on a [health promotion] campaign was seen as gross over-expenditure, while ten times that amount being spent each day on equipment was seen as necessary." Despite this, the costs of preventive services are still expected to be less than conventional health care.

II. Rationale for the Study

The need to describe and, if possible, quantify both the extent and direction of change in health policy, and to identify successful strategies for implementing change, has been stressed by many researchers. For example, Weiss and Hodgson (1992:121) write that "health policy shifts...are underway by many jurisdictions, so inquiry as to the real benefits of such moves is imperative." The justification for this particular study was to capture an understanding of health promotion and disease prevention practice within two very different health care jurisdictions, and to share across borders what constitutes real and positive implementation of good practice.

There are few American-Canadian comparisons in the literature, in large part due to the very different systems of financing health care. In the Canadian case, this difference has been linked to strong support for public financing and thus a reluctance to engage in comparative research that might undercut this support. Research that drew attention to potential strengths in the American model would be particularly problematic. However, the focus of the Clinton administration on health care has produced some American interest in looking abroad for comparisons. For example, two recent articles note the insights that Americans might gain from looking at the Canadian system (Roemer, 1991 and Marmor, 1993). In reference to health care financing, Marmor (1993:61) writes, "We need less talk about American uniqueness and more willingness to listen to what others can tell us." Similarly, Roemer (1991:681) begins his discussion by noting, "The thesis of this article is that there is much to be learned from the experience of a country similar in many ways to our own, but there are also differences between Canada and the United States." This study will contribute to the slowly growing literature involving cross-national comparisons and may begin to fill an important gap in that literature by examining, through qualitative means, differences and similarities in the two sites.

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It is important to stress at the outset, however, that no claim is being made that San Diego and Calgary are representative of their respective national health systems. Nor, for that matter, is any claim being made that San Diego is representative of even the California experience, or that the Calgary Regional Health Authority (CRHA) is typical of the 17 Regional Health Authorities in Alberta. As a consequence, readers should not assume that an implicit Canadian-American comparison lies behind the Calgary and San Diego discussions. What is assumed in the research design is that San Diego provides a good research site within which to explore the relationship between managed care and health promotion, that Calgary provides a good site to explore the impact of regionalization on health promotion, and that managed care and regionalization share enough structural characteristics to make useful comparisons across the two cases. It should also be stressed that managed care is not unique to San Diego County, although its penetration there is more extensive than it is across the United States. Similarly, regionalization is by no means unique to Calgary or Alberta, although the efforts made by the CRHA to address health promotion are close to the Canadian cutting edge.

In order to avoid the development, implementation or continuation of ineffective policies, processes and programs, it is critical to learn from experience in the field, to capture and evaluate active endeavours to reform patterns of health care delivery (Siler-Wells, 1988; Milio, 1988). Through the sharing of information about current practice, a better understanding of what does and does not work should emerge. Over time, the linking of applied research and dissemination efforts in relation to programs that promote and

sustain health within varying health systems can be instructive in building more generalizable predictors of success. It is to this end that we hope to contribute.

III. Research Methods

The research design is based on comparative qualitative case studies. Semi-structured interviews were conducted at the two sites, and snowball sampling of individuals and groups involved in health promotion identified key informants.

In San Diego, 27 interviews with 41 individuals were conducted in August 1998. Informants were identified via Internet searches; personal contact was made and snowball sampling began. Extensive field notes were taken during each interview and documentary evidence was collected. The following managed care and community organizations participated in the interviews:

In August, 1998, 27 interviews with 41 individuals were conducted in San Diego. In Calgary, 22 interviews with 25 individuals were conducted between November 1998 and March 1999.

- SHARP Rees-Stealy and SHARP Healthcare (3 individuals);
- Kaiser-Permanente (2 individuals);
- SCRIPPS Health (3 individuals);
- SCRIPPS Clinic (7 individuals);
- San Diego County (7 individuals);
- community providers – includes CHG; Children's Hospital and other non-profits (9 individuals);
- University of California at San Diego and San Diego State University (3 individuals); and
- other (7 individuals).

In Calgary, 22 interviews with 25 individuals were conducted between November 1998 and March 1999. Personal contact was made with key health authority managers and providers and snowball sampling was used to identify additional key informants. Interviews were tape-recorded, where possible, and field notes were taken. In many cases, documentary evidence was also collected. The following CRHA divisions and community organizations participated in the interviews:

- Population Health (7 individuals);
- Community Health Resources (6 individuals);
- Health System Development and Resources (7 individuals);
- Clinical Affairs (2 individuals);
- Calgary Board of Education (2 individuals); and
- United Way (1 individual).

The analysis was both specific and comparative, and began by the researchers creating

summaries from all sources. The summaries were based on the key questions in the interview guides and other emergent areas introduced by participants, including unexpected issues and themes, which were presented to the research team for input and feedback. Meta matrices, which are master charts assembling descriptive data from each of several cases in a standard format, were developed to analyze the data and compare across and within sites.

The issues which emerged include:

- the lack of a shared definition of health promotion and disease prevention in either site;
- a focus on the needs of the population versus the needs of the system, with variation in each site;
- differing leadership and partnership dynamics in the two sites; and
- an emphasis on outcome measurement in one site with the goal of measurement development in the other.

A discussion of each of these issues follows and forms the basis of our study findings.

IV. Towards Common Definitions & Goals

One of the recurring themes in both the Calgary and San Diego interviews is that definitions of health promotion and disease prevention are not agreed upon.

One of the recurring themes in both the Calgary and San Diego interviews is that definitions of health promotion and disease prevention are not agreed upon. Individuals define health promotion and disease prevention in very different ways. This section shares results from the case study data and builds on the existing literature to discuss: (1) the absence of common definitions; (2) limited versus broad definitions; (3) individual versus shared understanding; and (4) rhetorical versus real agreement. Table 1 identifies the issues associated with these definitional problems across both study sites.

The importance of clear goals and objectives, underpinned by shared definitions and conceptual understanding, is well documented within the planning and evaluation literature (see Bryson, 1988; Friedmann, 1987; Casebeer and Thurston, 1995). The difficulties in achieving clear and shared definitions for complex concepts such as "health," "health promotion" and "disease prevention" are equally highlighted in the literature (see Labonte, 1996; Casebeer and Hannah, 1998). Regarding the lack of an accepted definition, Ronald Labonte (1996:2) writes,

> There is no singularly accepted definition of health promotion, notwithstanding the World Health Organization's attempt to describe it as "the process of enabling people to increase control over and to improve their health...." For some, health promotion remains wedded to disease

Table 1: Issues Associated With Definitional Problems Across Both Sites		
	San Diego	**Calgary**
Common Definition	Little common agreement	Moving towards agreement
Scope of Definition	Narrow; front-end	Broader; full-spectrum
Nature of Understanding	Primarily individual; specified populations	Individual and population; geographic population
Goals	Expanding client population; legislative impetus	Managing client population; legislative impetus
Determinants of Health	Primarily chronic disease-focused for managed care organizations, broadly defined by the community	Broadly defined within the region
Rhetoric vs. Reality	Primarily rhetorical; efforts community-driven	Primarily rhetorical; efforts at sector-level or partner-driven

Evidence from both case study sites substantiates the ongoing challenge to find common definitions, particularly at the organizational or system-level.

> prevention, particularly behavioural change programs targeting smoking, nutrition, fitness and substance abuse.... To the extent that health promotion remains locked within the silos of disease prevention, relies upon mechanical models of health behaviour change, depends uncritically upon quantitative survey methods or borrows the model of randomized control trials from medical science to "prove" its efficacy or efficiency, it will suffer from many of the limitations that I will ascribe to population health.

In reference to broad definitions such as the World Health Organization's, there is some criticism of these as "hopelessly utopian and infeasible" as they identify nearly all activity and values as health-related (Frankish et al., 1996; Berlin, 1990; Crawford, 1977). Others argue in a similar fashion that planning and practice parameters are required so that expenditures do not go "unbounded" (Labonte, 1996; Rootman and Raeburn, 1994). Evidence from both case study sites substantiates the ongoing challenge to find common definitions, particularly at the organizational or system-level.

San Diego

Lack of Common Definitions: In San Diego County, common definitions of health promotion and disease prevention are rare. Among community organizations and those

closely associated with them through CHIP (Community Health Improvement Partners), a broad definition of health promotion is accepted. As one respondent said, "[literacy] ***is*** a health issue, friends." Another notes that, "Prevention is upstream; helping people get out is downstream." Some community providers even include access as part of their definition of health promotion and disease prevention, arguing that if you cannot get adequate medical care when required and regular physical examinations, disease prevention is not likely to happen. Some respondents are particularly adamant; for them, health promotion means "achieving access to a range of services." In contrast, most managed care organizations equate health promotion and disease prevention with the measurement of outcomes. Health promotion programs are also seen as a way to keep patients enrolled.

The following quotations illustrate the broad range of perspectives among San Diego respondents:

> Managed care enables a pro-active approach to: (1) preventive medicine; (2) disease management; and (3) case management. Wellness encompasses all three.

> Preventive medicine is not primarily a marketing tool – it is primarily a cost reduction strategy.

> Health promotion is management by objectives. You can't manage what you can't measure.

Across the board, however, prevention was not deemed a priority, although it was seen as an important service:

> Being friendly and local is more important than providing preventive medicine.

> Preventive programs may help keep people in a system even if they don't recruit [people] to that system.

Limited Definition: The need to take care of new MCO subscribers in order to save in the long-term is often stressed, indicating a service-related "front-end" understanding of health promotion and disease prevention: "In terms of preventive health, what types of resources are put into place to meet the needs of these patients? If we take care of them at the front-end, it is going to save us time and money at the other end." One respondent echoes the assumption that, although managed care organizations have the capacity to

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provide health promotion and disease prevention programs, they will not necessarily do so: "The promise of managed care to facilitate effective public health education and prevention is still there, but incentives in the right direction are non-existent."

Individual vs. Shared Understanding of Goals: The goals of health promotion shared by all respondents include saving time and money, keeping members enrolled and maintaining patient satisfaction. Community managed care organizations and their partners stand apart somewhat by being more likely to expand definitions of health promotion to include access and education, and to focus on health determinants and population health. In general, however, while the individual client is the focus of programming, the purpose is advancing the health of managed care populations, whether they be conventional or vulnerable populations. For example, chronic disease management is a strategy to this end shared by for-profit, non-profit and community managed care organizations.

Managed care organizations in San Diego County tend to focus on determinants of population health such as chronic diseases that are proven to have beneficial outcomes and cost-saving incentives.

Individual vs. Shared Understanding of Determinants: Managed care organizations in San Diego County tend to focus on risk determinants of population health such as chronic diseases that have proven interventions with beneficial outcomes and cost-saving incentives. In fact, every managed care organization that we spoke to had implemented programs related to diabetes and weight loss. In contrast to Calgary, the range of specific determinants identified by direct service providers was limited, although the wider community identified a broader range of determinants in its needs assessment (see Table 2). This list is exhaustive and includes community priorities such as AIDS, teenage pregnancy, tuberculosis and immunizations, all of which are major health concerns for San Diego residents. As one respondent noted, "We have to realize that if a person sitting across from you on the bus has tuberculosis, it doesn't matter if that person is not a citizen. It's a public health matter and we have to do something about it."

Table 2: Health Determinants Highlighted by Community Health Improvement Partners, San Diego County

Uninsured/underinsured	Substance abuse
Untreated mental illness	Intentional injuries
Family violence	Teenage pregnancy
Unintentional injuries	Tobacco use
AIDS	Obesity, nutrition and sedentary lifestyle
Cardiovascular disease	Cancer (breast and lung)
Infant mortality/low birth weight	Immunizations
Women's health/family planning	Tuberculosis
Diabetes	--

Rhetorical vs. Real Agreement: The differences and departures from agreement in relation to the components and scope of what health promotion and disease prevention entail suggest that even where shared values are "assumed," they may actually be more espoused than real. The myriad of separate health organizations, both for-profit and non-profit, may inevitably create a level of divergence in approaches to, and understanding of, health promotion and disease prevention. As well, differences in the relative importance of aspects of health and health care to a specified managed care organization's population of clients may broaden the gap between shared rhetoric and actual practice, particularly in relation to the underlying values health promotion encompasses.

Calgary

Support for Common Definitions: There is overwhelming support among the Calgary respondents for the formulation of common definitions for both health promotion and disease prevention. While only two senior managers in health promotion and healthy public policy were aware that definitions are included within the regional health promotion plan, others are aware that these definitions are "being developed":

> We have to work with our partners to at least have a common language and to use that framework for our planning. We are very aware that across the region a lot of people are doing health promotion and it may not in fact be congruent with our view of what health promotion is.

Others, however, stress the continuing lack of a common language and clear definition. As a student services representative in a local school division states,

> within the CRHA there are differing definitions of health promotion in terms of practice. And within our own organization, I think there are differing ideas of what health promotion means. And I think that...within the community there are different ideas around what health promotion is.

The sharing of knowledge around health promotion and disease prevention, and the effective negotiation and dissemination of common definitions among employees and partners within the CRHA, remain challenges for senior officials within the CRHA. They are nonetheless challenges made potentially easier within a regionalized system of care as health promotion and disease prevention can potentially be defined at the system level, across all service sectors and for the full population of the CRHA. No such potential exists in San Diego.

The sharing of knowledge around health promotion and disease prevention, and the effective negotiation and dissemination of common definitions among employees and partners within the CRHA, remain challenges for senior officials within the CRHA.

Broad Definitions: The definitions and expectations of health promotion and disease prevention remain very broad and relatively undefined at the current time. However, there is support for common definitions and recognition that these definitions can then shape specific goals.

There was general consensus among Calgary respondents that a relatively broad frame for definitions of health promotion and disease prevention was preferable. Only one respondent felt that the CRHA defines population health, health promotion and disease prevention too broadly.

Individual vs. Shared Understanding of Goals: With respect to the development of common goals, interviewers asked what the goals of the system or special programs were in terms of health promotion and/or disease prevention. This elicited both generalized and specific goals. Most respondents spoke of goals pertinent to their specific programs. Nonetheless, one overall goal that emerged is to incorporate health promotion and prevention life skills into a person's daily way of life. To achieve this, sub-goals such as education, the sharing and availability of information, and an increase in community capacity building were mentioned. For example, representatives from education have a very broad goal for health promotion: "...for kids to see that [health promotion is] not just a part of health class, but that it's a part of the way we are and who we are." Similarly, another educational representative articulates the goal of health promotion and disease prevention as "the hope of an eventual outcome of lifelong positive learning with good health." A trauma specialist's comment on goals is a good example of goal setting within a very specific framework: "the goal of the system is to reduce the level of injury and the – stop there, that is the goal."

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Individual vs. Shared Understanding of Determinants: Alongside diverse descriptions of broad goals for health promotion and disease prevention, respondents in Calgary speak at greater length about a broad range of health determinants targeted by health promotion or disease prevention activities. However, responses vary widely within both the CRHA and within other community or public sector partner organizations. As one individual involved with population health strategies states, "I think we're very much still in the learning phase in what [determinants] there are...isolating the evidence around the determinants [and establishing] what indicators are valid." Most Calgary study participants focus on a range of factors that determine or shape the health status of individuals or populations (see Table 3). As one leader in community health resources emphasizes,

> I wouldn't say determinants specifically are being targeted as the approach [but they] at least broaden our horizons so that we are working in

Table 3: Health Determinants Highlighted by Calgary Respondents	
Income	Education
Gender	Early childhood development
Maximized birth outcomes	Injury control
Community development	Stress reduction
Communications and literacy skills	Poverty
Smoking	Lack of physical activity
Socio-economic status	Rural areas
Age	Mental health
Any form of abuse	Social isolation
Medication	Breast self-exams

partnership with other jurisdictions or other departments of the government ministries who would have some kind of influence.

The approach to health promotion and disease prevention, therefore, is not solely focused on health determinants. Rather, a consideration of the "bigger picture" is utilized. As a leader in women's health explains,

Most Calgary study participants focus on a range of factors that determine or shape the health status of individuals or populations.

> We developed a model of care that we are beginning to implement here where we look at a woman's experience and we recognize that she is at the centre of that experience and how her experience includes economic factors, political factors, educational factors, how she was raised, [and other] influences in her life.

Only two people interviewed stated they were not targeting any specific health determinants. One of the two suggests that a focus on full-population coverage is sufficient: "We haven't delved into the determinants of health in any specific way. Our main vehicle goes to every household in the province and territories. And doing that, ...we are trying to cover everybody."

Rhetorical vs. Real Agreement: Relative to the San Diego case, there appears to be more evidence of concerted effort within the regionalized environment of the CRHA towards building and disseminating common understandings of health promotion and disease prevention, their goals, and the underlying determinants of health. However, this may mask a continuing divergence between the espousal of these aims and issues versus the real intent to adjust the culture and priorities of the health care system and its partners. It may also indicate a level of greater acceptance of the "language" of determinants of health and

population health promotion that exists in Canada as compared to the United States. Despite greater progress at a system level to articulate shared definitions and goals, the attainment of real agreement rather than shared rhetoric remains a challenge in the Calgary site as well.

Converging Evidence

It is clear that definitions of health promotion and disease prevention are not well-defined or commonly shared in either jurisdiction. It is also clear that in different ways, perhaps for different reasons, some parts of the health care "system" in both sites are addressing health promotion and disease prevention as increasingly important components of their activities. Concerns about access to basic primary health services underlie these efforts:

> We are very much aware within health care that we need a new approach, we need to do something that is going to allow us to get off the treadmill and to rationalize services so that those that have real needs are able to have those needs met. I think that primary health care is the solution.

It is clear that definitions of health promotion and disease prevention are not well-defined or commonly shared in either jurisdiction.

The role of primary health care as a recognized vehicle for innovation in health promotion and disease prevention may provide opportunities within both types of health care jurisdictions explored in this study.

V. Needs of the System vs. the Needs of the Population

There is a continuous interplay across both sites in balancing the needs of the health system with the needs of the population. Structural and access issues in both jurisdictions are entangled in this balancing act.

Population Health vs. Managed Care Populations

Considerable effort is being made across both sites to address the needs of the population. This common focus on vulnerable communities and targeted populations is evident despite the dramatic differences in the health systems. However, the main difference is that with managed care, populations are patient-based whereas with regionalization, patients are the whole population within a geographic area. While some MCOs may serve particular geographic areas, such as San Diego County, their population will only consist of those residents of the County who are members of their managed care plan or equivalent. Managed care populations consist of subscribers whereas regionalized populations consist of all the residents who live in a geographic area. Therefore, while regionalized systems in

Canada may practice population-health, managed care organizations in the United States practice what might be referred to as population-specific, client-focused or subscriber health.

Calgary

Population Focus: The goal of the health promotion division of the CRHA is to focus on the entire population, including vulnerable communities within Calgary. As one CRHA respondent states, "some of the underlying principles [within] health promotion are that you want to have multiple initiatives or points of intervention [and that these should] be complementary." This understanding has led the CRHA to participate in the formation of multiple partnerships with many agencies in the region. The combination of financial resources, talents, and energy increases access for vulnerable populations who can particularly benefit from health promotion and prevention.

Nevertheless, disseminating this "broader vision" of health care is often a challenge, one illustrated by three individuals within the CRHA:

> a lot of health professionals are involved in understanding health promotion at the individual level, but they don't often get the bigger picture...their role beyond that individual contact.

> what has begun to clarify for people is that there is a difference between primary care, which is only one level of care...and primary health care, which is a whole approach to looking at how we improve population health.

> So we are still in the process of trying to clarify what is the appropriate balance between responding to the needs of individuals versus the population as a whole.

Managed care populations consist of subscribers whereas regionalized populations consist of all the residents who live in a geographic area.

San Diego

Community Driven Efforts: In San Diego County, there is a recognition that vulnerable populations, like conventional populations, require access to health care services. However, responsibility for access has been left to local government agencies and community managed care organizations. These groups have been successful to a degree in outreach activities but not in convincing the larger managed care organizations to engage these populations in a significant way.

One example of a successful program is Healthy San Diego, which targets vulnerable populations in general and MediCal recipients in particular. It encourages managed care organizations to serve these populations in addition to their normal subscriber populations. The state requires that individuals undergo a physical exam within 200 days of signing up to the program. This is an aggressive and innovative initiative. Field workers give over 1,200 presentations a month and conduct these presentations in several languages. Healthy San Diego is a model for future program development in California. As one manager explains, "The state has invited us to review similar programs across California because of the success of Healthy San Diego."

Despite the apparent success of Healthy San Diego in bringing MediCal recipients into managed care organizations, access to health care services remains a challenge for vulnerable populations. Structural impediments including the large number of uninsured individuals create barriers for service providers. For example, at the community level there is concern about the overlap of programs. As a program officer for a border health initiative emphasized, "What we don't want to do is throw one more program into the mix." Duplication means that some areas may be overserved while others remain underserved.

Access to health care services remains a challenge for vulnerable populations in San Diego County.

Linked to concerns about overlap and duplication are concerns about the potential tension between fund raising necessities and community needs. For example, a manager in a community hospital asks, "Do you design a program to attract money or do you design a program for the community?" The manager is unsure whether the priority should be on projects that will raise money or on projects that the community requires. Often, these two priorities diverge.

Structural Distinctions

The structures of the two health systems vary dramatically and, as a consequence, each system creates its own demands and faces its unique health challenges.

Calgary

In the CRHA, health professionals are still struggling with the implementation of regionalization. For example, one individual who partners with the CRHA explains that,

> from the perspective of the system, even defining what the system is within this region [is difficult]. For example, what is the system around health promotion and disease prevention? What does it look like, who's considered part of it, what are the relationships within it?

Added to this is uncertainty about the direction in which Alberta Health and Wellness would like to see the health system move. As one individual notes,

> There is a lack of clear direction from Alberta Health and Wellness [about] health goals and health status improvement, and a mixed message in terms of what is the purpose of the health system. Is it to provide health services or is it to improve the status of the people it serves?

Thus, the rapidly changing internal environments within the CRHA and within the provincial system more broadly defined create challenges in addressing the needs of the population. They also create barriers in shifting the paradigm to a health promotion approach. This troublesome dynamic within the health system is expressed by a partner with the CRHA:

> Even as the system tries to change, ...it is like trying to change a flat tire on a car that is moving. We have no supports to be able to actually change. We know that things need to change, but we have limited resources in helping to make that change happen. But meanwhile, ...systems are overburdened, people are burning out, people that try to access services are coming in with higher levels of need.

The rapidly changing internal environments within the CRHA and within the provincial system more broadly defined create challenges in addressing the needs of the population.

San Diego

San Diego County is a competitive market for managed care organizations. Within the context of this market, health promotion and prevention are often seen as tools to attract and maintain clients. In this competitive environment, many people are able to switch health providers as often as they like, while others are locked in by employer contracts. (The insured elderly and indigent populations are the most mobile.) This in turn means that clients depend upon the chosen managed care organization to provide health promotion and disease prevention programs, which can be costly in terms of follow-up. In some cases, the programs are very rudimentary. As one respondent notes, "programs" often entail simply a pass to the local YMCA for a month; after that initial exercise, the client receives very little in the way of health promotion services. Clients, therefore, "have to read the fine print." Other programs are much more elaborate and varied in their capacity to meet client needs. They are run, however, on a cost-recovery basis, and thus access may depend on the client's own resources.

Another issue of concern at the systems level is that many programs are dependent upon external grants rather than standard operating revenues for their implementation and

maintenance. The increase in competition for funding directly affects the implementation of new programs in health promotion and disease prevention. It also affects the sustainability of existing programs as it is often more difficult to find funding to extend or continue existing programs than it is to find support for new initiatives.

Access to Health Promotion and Disease Prevention

The development of programs as points of entry to the health care system is important in both sites. Health promotion programs allow a larger segment of the population to access health care, with program development serving different purposes in each of the two sites.

Calgary

The CRHA sees health promotion programming as a supplemental access point to the health care system for the population. This adds to the primary points of access available to the population through acute care or family physicians. However, given the assumption that a publicly funded, universal health care system is generally accessible, there is not a heavy emphasis on improving access. With the CRHA facing a near-crisis funding situation in other parts of the system, promoting access to a universal system has an understandably low priority.

In San Diego County, many programs are dependent upon external grants rather than standard operating revenues for their implementation and maintenance.

San Diego

One of the most striking methods used to increase access in San Diego County are community outreach workers called Promo tores. They are used by community managed care organizations to reach the Latino community and, more specifically, undocumented immigrants within that community. Promo tores are trained by community agencies to provide health information and materials to the Latino community. They have been successful in the area of chronic disease education, particularly with respect to diabetes, which is more prevalent in the Latino community than in other populations.

It should be recognized, however, that increasing access to health services does not necessarily mean greater access to health promotion and disease prevention programs. As one researcher states, "Health promotion is a sexy thing in the marketplace but employers are not willing to pay for benefits down the road." Given the reality of a mobile workforce, keeping employees healthy in the long-run does not necessarily make economic sense for employers. Moreover, access to programs is often contingent upon the ability of programs to be profitable and produce positive outcomes. As a San Diego respondent notes, "It's easier for a program to lose money and continue if there are clear, demonstrable outcomes."

Needs Assessment

One feature common to both sites is the legal requirement to conduct needs assessments on a regular basis. However, due to structural variations between the two sites, there is greater participation and representation in the needs assessment done by the CRHA than done by the Community Health Improvement Partners (CHIP). The difference is that the CRHA represents and administers to the whole geographic region. Therefore, the needs assessment includes considerations from across the region. The California law addressing this issue applies only to non-profit managed care organizations; for-profit organizations do not participate in the needs assessment and information about their populations is not included in the analysis. Even so, the needs assessment conducted by CHIP in partnership with San Diego State University (SDSU) and the University of California at San Diego (UCSD) Departments of Public Health is an exceptional community effort.

Diverging Perspectives

As Table 4 illustrates, there are several similarities between the two sites with respect to achieving a balance between the needs of the population and the needs of the system. The most striking difference lies with the population base in each site. In San Diego County, the population base is limited to patient subscribers whereas the CRHA targets an entire geographic area.

Different population bases affect the focus of health promotion in the two sites: it is subscriber-centred in San Diego and geographically-centred in Calgary.

Table 4: Needs of the Population vs. Needs of the System

	San Diego	Calgary
Population Base	Limited to patient subscribers	Geographic
Focus of Health Promotion	Client-centred	Calgary-centred including vulnerable populations
Reasons for Health Promotion and Disease Prevention Programs	Needs of the client populations; cost reduction; increase patient subscribers	Needs of the geographic population; other reasons not emphasized
System Focus	Acute care	Acute care
Priority of Health Promotion and Disease Prevention Within the System	Low even though legislative impetus	Low even though legislative impetus; development is evident (i.e., Leader, Healthy Public Policy)
Needs Assessment	Required by law that all non-profit MCOs conduct assessment of subscriber populations	Required by law that the CRHA conduct assessment of geographic population

These different population bases affect the focus of health promotion in the two sites: it is subscriber-centred in San Diego and geographically-centred in Calgary. The geographical population base allows for a community-centred approach to health promotion program delivery. Under this system, vulnerable populations are included, whereas in San Diego vulnerable populations are segmented to specific programs, such as Healthy San Diego, and the community providers who depend on federal and state grants for much of their funding.

Closely linked to the differing population bases are the reasons for implementing health promotion and disease prevention programs in the two locations. As previously mentioned, health promotion is often seen as a marketing tool to increase the clientele of MCOs, and as a cost reduction strategy from a long-term financial perspective. In Calgary, the needs of the geographic population are addressed through health promotion programs, although there remains some ambivalence about priorities given to the health of the individual and the health of the population.

A commonality across both sites is that the system focus is still on acute care. The paradigm shift from primary care to the more inclusive primary health care has not yet occurred.

A commonality across both sites is that the system focus is still on acute care. The paradigm shift from primary care to the more inclusive primary health care has not yet occurred. The business of health care in both San Diego County and the CRHA remains focused on provision of acute care services. Thus, health promotion and disease prevention have a relatively low priority despite the legislative impetus that exists in both sites. Nonetheless, an increased commitment to health promotion and disease prevention activities is clearly more evident in the Calgary site. For example, the region has staff positions dedicated to population health and healthy public policy, and the CRHA Board has adopted a primary care partnership strategy for future health care developments.

VI. Leadership & Partnerships

Much of our discussion to this point has focused on features of health promotion in Calgary and San Diego, and on managed care in San Diego and regionalization in Calgary. When the discussion is cast at this level it is possible to lose sight of the unique contributions of particular individuals and innovative partnerships.

Leadership

A leader has the capacity to command authority and influence the behaviour of others. In San Diego, innovative efforts are generally driven by individual leaders. In Calgary, collaborative partnerships drive innovative programs. Authority is the linking thread across both sites; whether it is individuals or a partnership of individuals, successful innovation requires the capacity to influence.

An important question with respect to the continuity of health promotion initiatives beyond their initial impetus underlies the examples that follow. Ideally, successful initiatives will acquire organizational permanence, and therefore the capacity to withstand leadership turnover and renewal. This capacity is secure in neither site although the bureaucratic character of the CRHA offers greater potential in this respect than does the competitive and unstable MCO environment in San Diego.

San Diego

In San Diego County, leadership is a very important factor in the successful implementation of health promotion and disease prevention programming. Of those interviewed, most were leaders who direct their organizations in innovative health promotion and disease prevention initiatives.

One such individual has been involved in disease prevention for over 20 years. He started the Department of Preventive Medicine for Southern California Kaiser Permanente (KP) in 1974. The department involves a center that provides clients with bio-psycho-social medical evaluations. The Health Appraisal program is so successful that individuals who are not members of KP are willing to pay $195 US to use the service. The risk abatement programs make sufficient revenue to pay for their own operations and to support other programs. Despite the financial success, the longevity of the program is a function of ongoing, vigorous individual leadership often exercised in the face of considerable organizational resistance.

Ideally, successful initiatives will acquire organizational permanence, and therefore the capacity to withstand leadership turnover and renewal.

The Medical Director of Quality Management at SHARP Rees-Stealy is another leader within his organization. He is particularly mindful of the need for information in population health, and has convinced the divisions of the hospital to work together to share information. He has also instituted HEDIS at the physician level. HEDIS is an auditing program which rates MCOs against one another in certain areas such as the number of cesarean sections performed. He uses HEDIS within his organization so that doctors can compare their performance against one another, thereby promoting overall improvement: "One thing you must know is that doctors are incredibly competitive. I use that to the advantage of our organization and the patient."

A physician within SCRIPPS is yet another visionary leader. She is the Medical Director of the SCRIPPS Centre for Integrative Medicine. A surgeon, she believes in eating healthy to live long. Unlike some surgeons, she is concerned not simply with curing what ails the patient but also with preventing it. She is the physician leader of a team of physicians and researchers who are developing and implementing the first integrated alternative medicine program in a managed care organization. In presentations about this innovation, she

admits that her status as a heart surgeon provides legitimacy to the alternative medicine initiative.

Calgary

In Calgary, partnerships appear to be more important than individual leadership, although within the administrative structure of the CRHA there are several people in leadership or visionary positions with respect to health promotion. Those who are responsible for health promotion and healthy public policy clearly fill the role of leaders. Well versed in both the academic literature and the state of health promotion within the CRHA and the wider community, these individuals are essential players in a regionalized system of health care. For example, a health care manager in the CRHA with a passionate vision of health promotion is promoting a primary health care model that centres on health promotion. The focus is on individual capacity building; the goal to help people take control of their day-to-day life.

In Calgary, partnerships appear to be more important than individual leadership, although within the administrative structure of the CRHA there are several people in leadership or visionary positions with respect to health promotion.

The United Way, a partner to the CRHA, is an example of an *organization* that is playing a leadership role. The leadership efforts of the United Way are remarkable. Their community approach to program delivery, their focus on a population health perspective, and their prevention efforts bring together a multitude of organizations with a common goal. One associate described their role as

> the prevention kind of role, the notion that you are hopefully going to influence conditions and personal situations, family, and community situations so that it doesn't become in need of more intervention and even possibly, to a critical point, to ensure that individuals, families, and communities have the supports that they need to be able to have optimal health, again in the broadest sense of the word.

As an organization free of constrictive mandates, the United Way is able to form unique, effective partnerships with many organizations. This allows for the development of innovative initiatives that target sectors of the population that may not have access to health promotion and disease prevention programs.

Partnerships

Leadership can also contribute to successful partnerships. Some of the most interesting leaders in San Diego County were leaders not because they controlled situations but because they had the vision to partner with others. They were willing to give up some of

their own organizational control for community benefit. Within the competitive MCO environment, however, these individuals are the exception rather than the rule. In Calgary, by contrast, partnerships are very much a part of the fabric of the CRHA. There is an extensive web of partnerships in a variety of areas. The following examples illustrate that partnerships in health promotion and disease prevention are important in both sites from a population health perspective and for developing community capacity.

San Diego

While there are many barriers to building partnerships in San Diego County, there is also a legal requirement to do so. Senate Bill 697, which became law in 1994, requires all non-profit organizations in California to "show community benefit." Specifically, SB 697 created a new mandate for non-profit, private hospitals which requires them to:

- explicate within the hospital's mission statement a reference to serving its community (one time requirement);
- conduct a health needs assessment of its community (every three years);
- prepare a community benefit plan and report (annually); and
- submit the benefit plan to the Office of Statewide Health Planning and Development (annually).

Some of the most interesting leaders in San Diego County were leaders not because they controlled situations but because they had the vision to partner with others. They were willing to give up some of their own organizational control for community benefit.

The legislation has led to some interesting partnerships for it now makes sense for non-profit MCOs to work together. As a university researcher who participated in the study states, "HMOs would like to do something collectively on the health promotion front...there are few incentives, however, for anyone to step out ahead of the pack."

Even with SB 697, it is difficult to get MCOs involved in health promotion and disease prevention in the community; it takes a neutral party who does not compete directly with MCOs to bring them together. The most successful partnership in this respect is Community Health Improvement Partners (CHIP). Since its inception, CHIP has performed a County-wide needs assessment and set priorities for the community. The CHIP coalition now comprises 26 organizations. It first met in June 1995 at the invitation of three neutral organizations: the Hospital Council of San Diego and Imperial Counties (now the Healthcare Association); the County of San Diego Department of Health Services (now Health and Human Services), and the Graduate School of Public Health at San Diego State University.[4] The purpose of the meeting was to consider a collaborative approach to the requirements of SB 697. As one physician affiliated with SCRIPPS Health noted, MCOs cannot always be out there in a community but they can "be a partner – help – people are saying *yes*. They know the stuff is important to do." CHIP has provided the necessary vehicle.

SB 697 also gave rise to a program called School Health Improvement Partners (SHIP), another example of a neutral party bringing MCOs together. In this case, it was Healthy San Diego. The County holds Healthy San Diego meetings once a month with the MCOs that deliver health care services to MediCal recipients. Sometimes, other individuals are invited to the meetings and may make presentations. At one such meeting a pediatrician challenged the MCOs involved in Healthy San Diego to work with him on a project, and SHIP was born. As the physician who started SHIP writes, "Many school staffs have come to realize that any child's good health (including those without special health needs) is an important ingredient to his or her success in learning" (Taras, 1997:735). SHIP involves partnerships between the educational sector, physicians, families and MCOs. There are a variety of programs to facilitate the health of children including asthma assistance and education, on-site tuberculosis tests, and health information.

Another program involves SCRIPPS and SHARP, two competing MCOs coming together to improve maternal and child health through smoking cessation programs for mothers during and after pregnancy. These programs include information, cessation assistance, and a cash reward to program participants both for staying in the program and seeing it through to finish. The director of the Center for Healthier Communities for Children explained that SB 697 was not the only reason this program happened. He noted that the CEO of Children's Hospital met with the CEOs of SCRIPPS and SHARP and challenged them to do something together. They agreed and this program resulted.

Apart from SB 697, partnerships in the San Diego site are not encouraged by the health system as they are within the CRHA.

The partnership incentives which have been created for non-profit MCOs do not extend to for-profit MCOs. Although the for-profit MCOs do not tend to be as large as some of the non-profits, they are abundant and are not required to show community benefit. As one for-profit provider explains, "Our goals are to serve our own patients. It doesn't make sense to get together with others."

A researcher underscored the lack of cooperation among for-profits in comparison to the cooperation that takes place among non-profits: "Have there been positive examples of medical providers coming together? I can't give you a concrete example. There might be initiatives." If for-profit MCOs do partner, it tends to be with pharmaceutical companies. At times, they also sit on external committees which give them an opportunity to find out what other organizations are doing.

Apart from SB 697, therefore, partnerships in the San Diego site are not encouraged by the health system as they are within the CRHA. Leadership, and the promotion of leaders, are the most successful strategies in the competitive health environment of San Diego County.

Calgary

There is overwhelming support for the formation of partnerships within the CRHA. The partnerships range from the federal, provincial and municipal levels of government through to national organizations such as the Red Cross and the Canadian Cancer Society to many local organizations. The partnerships even extend to community and church organizations such as the Boys and Girls Club and the Islamic Association. The following statements from CRHA respondents capture the organizational spirit:

> We always try to encourage partnerships, working in a collaborative manner, building on what is successful in Calgary, and then in our own way try to make sure that we are working in partnership and collaboration with other funders.

> What we have gained is the maximizing of efforts with other partners and working more as an integrated team across the region.

> whenever we have brought another community partner in, for every dollar we spend, they bring in two or three extra dollars. I am really encouraged how my colleagues in the division are starting to use more partnerships.

As a result of the creation of an extensive web of partnerships, innovative programs are being implemented in Calgary.

As a result of the creation of an extensive web of partnerships, innovative programs are being implemented. For example, the Alberta Centre for Injury Control and Research emerged out of a coordinated strategy implemented by many different groups interested in injury prevention. These groups included agencies such as police and fire departments, traffic designers, insurance companies, Alberta Health and Wellness, and hospital trauma departments.

The CRHA's focus on a lifestyle approach to health promotion and disease prevention culminated in the Active Living campaign, a partnership with the Fitness and Lifestyle Centre at the University of Calgary, and with the Stay and Play, Park and Play campaign run by Calgary Parks and Recreation. These programs focus on prevention measures such as sun safety (wearing hats and sunscreen) and health promotion through fitness and lifestyle issues. The partnerships with the University of Calgary and Calgary Parks and Recreation improve overall health, as individuals internalize the health promotion message. For example, all summer instructors that work for the City of Calgary are required to wear sunscreen and hats. These instructors, then, become role models for the children they instruct over the summer holidays.

Although there are significant innovations and an emerging network of organizations for health promotion and prevention in Calgary, there are also challenges and barriers to partnership. As an associate with the United Way states,

> We are in the process of trying to work with a variety of other funders on a funding partnership where our goal is to provide a comprehensive approach to low income families...everybody is very bound by their legislation in terms of their mandate...so there might be collective interest but it is very frustrating in terms of who is bound by what kind of clients they can or cannot have involved in that kind of program.

Moreover, there is a feeling among those interviewed that overlap and duplication exist, and that further role clarification is needed:

Although there are significant innovations and an emerging network of organizations for health promotion and prevention in Calgary, there are also challenges and barriers to partnership.

> I think we have set up artificial barriers that never were there before.... So I think we have introduced a complexity that didn't need to be there.

> With regionalization there have been some pluses but we are also a huge bureaucracy. We have a lot more process than we had before, and a lot more people to talk to...that's good but sometimes it takes a lot longer to do the work you need to.

The governance structure of regionalization also poses challenges to those in health promotion and disease prevention. There is concern regarding the hierarchical nature of the organizational structure and the limits imposed through legislation and mandates: "you know, we really have a very acute-focused, crisis-focused system. So it is...a disincentive, really because a lot of the work that I am talking about is considered fluff." This problematic conception of health promotion and disease prevention may be related to the lack of a commonly understood definition of health promotion and disease prevention among professionals within the CRHA.

Furthermore, power struggles, "turf wars" and dissonance within the health authority act as disincentives to some respondents. Other disincentives articulated revolve around funding. As a trauma specialist states, "the CRHA doesn't have any incentive, it is running a deficit. And it's up to Alberta Health to spend less money and provide more service, so I am not sure what incentive they have."

Conversely, there is recognition that the CRHA and provincial government have made a commitment to health promotion and disease prevention. For example, regionalization

has helped create a unique stroke prevention clinic that is the first of its kind in Canada. The clinic provides both stroke prevention and acute care. As a doctor in the Stroke Program states,

> the government, by being regionalized, is absolutely essential in developing this kind of program. The biggest success is actually, I think, at the end of the day just seeing the people who we have turned around who were disabled by a stroke, who walk out of here intact.

Diverging Innovation Dynamics

Innovation across the two sites is achieved through different means, as Table 5 illustrates. Although leaders and partnerships exist in both sites, each is considerably more successful in their respective health environments. Leadership works well in San Diego and innovative strides are being taken in health promotion and disease prevention. The Health Appraisal is one strong example of this. In the CRHA, partnerships are the method for successful innovation, as a member of the division of Community Health Resources underlines, "we know we can maximize resources by working with others. We want to empower or enable others to do for themselves long-term." Partnering facilitates a

Innovation across the two sites is achieved through different means.

Table 5: Leadership & Partnerships: Key Issues

	San Diego	Calgary
Leadership	Individually driven	Evolves and develops through partnerships
Partnering Opportunities	Difficult but possible because of neutral parties and legislative impetus	Abundant and complex
Legislative Impetus for Health Promotion and Disease Prevention	SB 697 includes non-profit MCOs but not for-profit MCOs	Regional Health Authorities Act includes whole population
Innovation	Via individual leadership, organizational impetus, and legislative impetus	Via partnerships, organizational impetus and legislative impetus
Health Public Policy	Driven by state and local government rather than by MCOs, if at all	CRHA has full-time position: Leader, Healthy Public Policy; dedicated resources and goals
Community Initiatives	Driven by the community with some MCO involvement due to SB 697	Driven by both the community at-large and the CRHA

community-based approach to health promotion and overcomes some of the financial barriers and constraints within the current health system.

There are drawbacks, however, to the predominance of leaders in San Diego County and partners in the CRHA. In the field of health promotion, MCOs rely on leadership to serve their clients; partnerships are seen as ineffective, particularly by for-profit MCOs. In Calgary, conversely, there appears to be an unwillingness of individuals to seek out, or promote themselves as leaders. Perhaps this is related to the authority and power an individual has versus a partnership of individuals. As one respondent underscores, "I believe it's a partnership and partnership is equal, it's not one more than the other...." Nonetheless, and drawbacks notwithstanding, what is apparent across both sites is an incremental, innovative shift, whether through the force of individual leadership or collective partnerships, towards implementing health promotion and disease prevention efforts into the everyday practice of health care.

Outcome measurement is one area where the different organizational structures for health care service delivery give rise to two very different approaches. In San Diego County, outcome measurement is commonplace. Conversely, in Calgary, very few programs and services receive formal evaluation.

VII. Measuring Outcomes

Outcome measurement is one area where the different organizational structures for health care service delivery give rise to two very different approaches. In San Diego County, outcome measurement is commonplace. This does not mean that the measures are always accurate, as one of the respondents underscored. Nevertheless, they are an aspect of every program and service in managed care organizations and those run by community providers. Conversely, in Calgary, very few programs and services receive formal or ongoing evaluation. Measurement of outcomes is often connected with an evaluation requirement in grant funding. The examples and discussion in this section illustrate two very different outcome environments.

San Diego

Necessity of Outcomes: In San Diego County and in managed care more generally, measurement of outcomes is emphasized. As one respondent notes, "Everyone is talking about measurement." Interestingly, comments about outcomes tend to focus on the positive challenges they present and how successful outcomes might allow programs to continue even if they do not save money or time. There was not a lot of difference in attitude among community, non-profit and for-profit MCOs regarding the necessity of measuring outcomes.

One physician in a non-profit MCO explained that the nature of health care means that outcomes must not depend solely on saving money:

> Within certain parameters, costs are irrelevant. If you improve health, you improve the quality of life. If you save – good; if it's cost-neutral – good; if it costs a little more and helps – good. But if there is no or only marginal improvement and it costs more, then it is poor.

Need for Reliable Outcomes and Information Technologies: Both community organizations and non-profit MCOs are concerned with the need to collect data in an appropriate manner for outcome measures to be reliable. As a physician respondent remarks, "Measuring accountability is fine as long as measures are accurate." There are also concerns about being able to collect information and having the needed information technologies. One physician points out that an information infrastructure is essential if management by objectives is to take place. In tandem, a researcher notes, "We've got to informate the system."

Generally, there was confidence that programs would receive positive evaluations. Outcomes were viewed as challenges and seen as required. As a physician administrator at the Children's Hospital stressed, "Public health is always challenged in terms of measurement, but I see it as an opportunity." For example, a provider indicates that collection of data can show that the program is effective: "It's easier for a program to lose money and continue if there are clear, demonstrable outcomes."

Measuring accountability is fine as long as measures are accurate.

High Cost of Auditing: Other issues included the need to collect an incredible amount of data. A nurse who worked in quality management for one of the MCOs explained that there are yearly audits including HEDIS and NCQA (National Committee on Quality Assurance). In addition, there is a review process every year. Almost always, some sort of audit or audit preparation is taking place. All organizations, including the community ones, are involved in yearly audits which cost money and time. One community clinic in the study faces fifteen audits a year, with many taking up to two weeks each.

Several organizations provided examples of their outcomes, examples which show the determination and ability cf managed care organizations to measure outcomes. However, they also indicate limits imposed by the measurement tools:

- "48% of weight loss participants lose 60% of goal weight in two years and 60% keep it off."
- "Promo tores model is successful. Outreach to 13,000 in four months."
- "Urgent care is highly successful. Repeat visits $95; an average ER visit is $700...at the high end, urgent care is $300 and ER is $3,000 per visit, and we cannot discern different care."
- "30% success rate a year out for smoking cessation."
- "60% success rate for self-selection for Smoke-No-More."

Although San Diego respondents were generally positive regarding outcome measures, they point out many problems with attempts to measure outcomes in health promotion and disease prevention. These include:

- benefits usually only evident over long-term;
- high costs associated with measuring outcomes;
- public apathy to health promotion and disease prevention ("No matter how good our programs are, we're not sure our patients understand. It's difficult to commit resources to preventive services because of public indifference.");
- more cost-benefit analysis needed and less cost analysis only;
- problem of evaluating community benefit; and
- inherent problem of evaluating prevention ("How do you evaluate what never happened?").

Calgary

Most Calgary respondents suggest that evaluating outcomes is in the infant stage of development.

In sharp contrast, most Calgary respondents suggest that evaluating outcomes is in the infant stage of development. Several respondents state there is evaluation, but without vigorous outcome measures. For example, a leader in education services said they do not engage in formal evaluation, but mainly informal feedback such as "happiness indexes," statistics on phone and web site usage, and the types and amounts of various brochures taken off information display racks located in the emergency waiting room. As a representative for the Calgary Board of Education underscores, "We're real soft on [evaluation]. We just say in our minds: trust us, we're doing good stuff. We have to do it a better way." Although there is a good deal of work currently being done within the CRHA to improve evaluation processes, there is also a long way to go.

Linked to the complexity of measuring outcomes is the development of sound indicators. The controversies surrounding the range of indicators for a healthy lifestyle make it difficult to establish and target specific indicators. As an officer for prevention services emphasizes,

> I think that this is an area that is quite weak for us, and I think it is an area where we have always known we need to be better at and that we have wanted to spend more time and energy in learning about and...to put in very solid evaluation strategies.

However, there is more advanced outcome evaluation in the area of acute care. There is, for instance, the Alberta Trauma Registry that captures information on patients admitted with

severe injury. As a trauma associate describes,

> We are able to compare our outcomes with the Major Trauma Outcome Study which was a large study which set benchmarks and was published in the mid 1980s. It included data on over 80,000 major trauma admissions in North America.

There is also a financial challenge to improving measuring outcomes. For example, a health promotion consultant trying to identify indicators and outcomes recognizes that they are still in the infant stages, but expresses concern that implementation is dependent upon finances. Currently, some programs and services, such as the Best Beginnings Program, the Comprehensive School Health Initiative, the 8th & 8th Clinic, and the Airdrie Regional Health Centre are being allocated funds to develop evaluation measures. Others are beginning to use the concept of "potential years of life lost" to differentiate disease conditions. The next stage, according to an officer for public health, is to use "quality adjusted life expectancy" or "healthy years of life expectancy" to determine resource allocation.

The measurement of outcomes is an issue that resonates in both sites. The main similarity is the high cost associated with measurement.

Some respondents express concern over the importance associated with the evaluation of outcomes. As a leader in women's health remarked,

> it is a big thing with the Department of Health...for the next year [to get] some evaluation in place. We are not going to start out with a hundred indicators, we are going to start out now very slowly and make sure that we can make a difference. We believe we make a difference. Women will tell us we make a difference but I don't know if I could prove it to a funder, and that's what I want to start doing, working down that road and saying "this is our effort."

It is recognized that dramatic improvements need to be made in measuring outcomes. However, there is also concern about ensuring a high quality measurement process. This is contingent, in many cases, on continual financial support from the CRHA.

Searching for Evidence

The measurement of outcomes is an issue that resonates in both sites (see Table 6). The main similarity is the high cost associated with measurement; in both sites, costs are a barrier or at least a challenge. However, there is a marked difference in the success of, and the emphasis on, measurement in San Diego County and the CRHA. In the American site,

Table 6: Issues Related to Outcome Measurement		
	San Diego	**Calgary**
Cost of Measurement	High	High
Number of Evaluations	High – an expectation of business	Very few
Incentives to Evaluate	Structural (HEDIS and NCQA)	Few; some grant requirements
Information Technology	Emphasized as very important	Noted by one respondent

there are high numbers of evaluations and measurement outcomes are an expected cost of doing business. There are also structural incentives such as private accrediting bodies – HEDIS and NCQA – which require data to determine if an MCO will be approved. In contrast, the CRHA has few incentives, as illustrated by this respondent:

There is a significant difference in the way that measurement is viewed by professionals in the two sites.

> I would say that the incentives are very soft, a sense of doing the right thing, a sense of buying into a better future. I think there is so little feeling of proof about some of these things and the steps of change are so experimental that it is a pretty tough sell.

There is a significant difference in the way that measurement is viewed by professionals in the two sites. In San Diego, both community and managed care organizations see measurement of outcomes as essential. Even when difficult, they see them as "challenges" that have potential benefits. In comparison, respondents from the CRHA appear skeptical of an emphasis on measurement. As one respondent asks,

> How do we ensure that we aren't and agencies aren't...and the "we" in the collective sense...skimming to meet our goals in terms of these outcomes that we set for ourselves and that organizations set for themselves and the government sets for itself?

In addition, there is a difference in the perceived need for information technologies in order to better measure outcomes. In the American site, there is a recognition of the need to "informate the system." Management by objectives, or managed care, requires information technology for surveillance, data collection and analysis. Of those interviewed in Calgary, only one respondent mentioned information technology, and did so only in passing.

Finally, both sites are challenged by the difficulty in finding ways to measure long-term outcomes and benefits from health promotion and disease prevention. The dilemma remains that financially-driven inputs and outputs derived from short-term health service activity are easier to measure, and therefore tend to carry greater weight in system planning.

VIII. Conclusion

This study has identified and discussed four main issues in relation to health promotion and disease prevention in Calgary and San Diego County: (1) a lack of a shared definition of health promotion and/or disease prevention; (2) a focus on balancing the needs of the population with the needs of the system; (3) a dynamic between partnership and leadership in the two jurisdictions; and (4) the necessity and development of outcome measures (see Table 7).

This study suggests that managed care is limited in practicing population health while a regionalized system has the benefit of service to a whole geographic population base. In this sense, a regionalized system may be better suited to the equitable delivery of community-based care.

Table 7: Common Frames for Health Promotion & Disease Prevention

	US Case Study	Canadian Case Study
Common Definitions/Goals	No agreed definitions	Attempting to formulate
Population/System Needs	Significant uninsured population; variation in plan coverage	Barriers relate to resource issues; geographic, cultural, or determinant driven
Leadership/Partnership	Individual champions exist; partnerships difficult in competitive environment	Organizational commitment; evidence of partnership activity
Outcomes	Part of the culture; limited orientation	Driven by both the community at-large and the CRHA

Part of the rationale of the study was based on the assumption that managed care and regionalization share some structural characteristics that make the comparison between the two sites useful. These structural characteristics come primarily from the literature on managed care and disease prevention, and include: (a) population-based health care; (b) populations other than mainstream; (c) organizational incentives; and (d) financial incentives. However, the study finds that these structural characteristics, which at first appear similar, are very different in the two sites and give rise to somewhat different change processes and barriers (see Table 8).

As discussed at length in Section V, the population foci of managed care and regionalization vary significantly. Moreover, the vulnerable populations served by regionalization are

This study shows how managed care and regionalization differ systematically. This difference has implications for future research and for health system change because it exposes the challenge managed care has in providing population health and it emphasizes the potential benefits of regionalization in this respect.

Table 8: Variation in Structural Characteristics Between the Two Sites

	US Case Study	Canadian Case Study
Population-Base	Select populations Limited to subscriber populations	Whole population Focus on geographic populations
Populations Other than Mainstream	Some targeted subscribers (e.g. seniors on Medicaid) Community MCOs serve insured indigent populations County (Healthy San Diego) acts as a liaison for indigent populations to sign up as subscribers to eight major managed care organizations Needs assessments undertaken by community help involve non-profits in program definition Chronic disease management is a common health promotion strategy	Served within whole population through population health promotion strategy Some programs targeted to particular populations Health determinants and needs assessment help define programs
Organizational Incentives	Emphasis on surveillance of the population and a corresponding recognition of the necessity of outcome measures Partner notification is possible but there is some ambivalence Health promotion programs can be an incentive for patients to subscribe to a managed care plan. Some respondents identified these programs as a marketing strategy	Surveillance of the whole population is ongoing but linked to population health approach rather than system need/organizational incentive
Financial Incentives	Health promotion and disease prevention programs are identified as cost-saving measures Savings are over the long-term. Some concerns about proving "global outcomes" and therefore an inability to create financial incentives	Cost-savings not explicitly identified as an incentive to provide programs Resources (the lack thereof) are, in fact, a barrier to program provision rather than an incentive

considered part of the whole population, while in order to receive health services through managed care they must be subscribers. Population health is a primary concern within public health. This study suggests that managed care is limited in practicing population health while a regionalized system has the benefit of service to a whole geographic population base. In this sense, a regionalized system may be better suited to the equitable

delivery of community-based care. This finding is supported by the large number of partners that the Calgary Regional Health Authority has been able to cultivate. This finding emphasizes that regionalized systems are not the same as managed care organizations, at least in the American sense. A regionalized system is not only concerned with "our patients" but with the whole population in the community, whether sick or healthy.

This distinction leads nicely into a discussion of financial incentives. Respondents from San Diego managed care organizations are very concerned with the financial benefits of health promotion and disease prevention, including those that might be gained via marketing, while respondents from the CRHA do not mention saving money in the long- or short-term. Their concern was primarily with what could be done for the Calgary population by way of services. This is not to overstate the breadth of programs actually delivered; indeed, health promotion is not a priority in either jurisdiction. However, it is seen as part of health care in one and a part of business in the other.

The study supports the existing literature on health care systems, prevention and health promotion services by confirming previous findings regarding a lack of real incentive for systems to provide programs in these areas, even though the system managers may be able to identify reasons for provision. Moreover, this study shows how managed care and regionalization differ systematically. This difference has implications for future research and for health system change because it exposes the challenge managed care has in providing population health and it emphasizes the potential benefits of regionalization in this respect. As well, this study raises questions about the extent to which legislation results in significant change. In both jurisdictions, there is a legal impetus to provide health promotion and disease prevention services, yet the degree of service remains limited. Indeed, legislation may be helpful in getting programs started but the depth and breadth of service that legislative mandates can inspire is still in question.

The research suggests the need for further study, investigating managed care and regionalized systems at greater length and within other jurisdictions.

Overall, there are questions regarding the relationship between problem definition and service delivery. We have underscored that both systems and sites lack shared definitions of health promotion and disease prevention. Is the problem defined so broadly that there is little in the way of detailed programming and delivery? Or is a limited definition similarly limiting the amount of programs and services available? Finally, this comparative case shows the limitations of studying different systems with different organizational and financial incentives. The research suggests the need for further study, investigating managed care and regionalized systems at greater length and within other jurisdictions. ■

APPENDIX

The Canadian Context

Today in Canada there is a recognized vision for health care, which sustains and improves health. Lalonde (1974) and Epp (1986) led the way in creating a more holistic philosophy of health care and health. The Canada Health Act (1984) stipulated five central principles that remain the cornerstones for testing health policy shifts. Canadian health care services must be:

- comprehensive;
- universal;
- portable;
- accessible; and
- publicly administered.

While these federal principles are being interpreted somewhat differently (and sometimes challenged) by individual provinces, they continue to provide guidelines for Canadian health reform alongside the growing focus on multi-sectoral determinants of health, and prevention and promotion as important aspects of care. These combined tenets for Canadian health policy are echoed in more recent royal commissions and other national and provincial policy reports. Mhatre and Deber (1992) have surveyed the recent provincial health policy reviews and conclude that "Canadian policy makers are setting new policy goals, within resource constraints, primarily to achieve equity of access to health" (645). Their research identifies a number of common themes involving fundamental change and requiring major shifts in our understanding of health and health care services. Several of these themes relate directly to emphasizing the importance of health promotion and disease prevention activity:

- ***Broadening*** the definition of health with the collaboration of multiple sectors;
- ***Shifting*** emphasis from curing illness to promoting health and preventing disease;
- ***Switching*** focus to community-based rather than institution-based care;
- ***Providing*** more opportunity for individuals to participate with service providers in making decisions on health choices and policies (extracted from Mhatre and Deber, 1992: 655, emphasis added).

The recently completed work of the National Forum on Health should have significant impact on shaping some of the priorities for health promotion across Canada. The Forum's consultation document posed the following challenge to the health sector:

> The ultimate goal of everything we do in the health sector is the improvement in health status and quality of life at the level of populations and individuals. The acid test is whether services, programs and policies have improved health beyond what could have been achieved by doing something else with the same resources or by doing nothing at all. (National Forum, 1997)

Examples of provincial policy that may prove responsive to some of these national concerns are numerous. It is imperative to remember that, in Canada, health care is a provincial responsibility. Therefore, while the principles embedded within the federal act attempt to provide continuity and consistency, the actual authority lies with the provinces. To some extent, the reorientation of health care systems has taken some similar pathways in most provinces. For example, a favoured response at the provincial level of control has been to delegate responsibilities to sub-provincial or "regional" levels. As a result, "regionalization" is one health policy shift occurring across Canada. Within or alongside this shift, a growing focus on health promotion and disease prevention remains a common goal:

> All provinces have expressed a commitment to shifting the emphasis of their health systems away from institutionally-based delivery models to community-based models which [in turn] place increased emphasis on health promotion and [illness] prevention." (Health Canada, 1996)

The Alberta Context

Provincial governments across Canada have introduced some form of regionalization into their health care systems. The context surrounding regionalization in Alberta is now well known and documented within numerous government reports, and has found its way into the public domain via news reports and all manner of media coverage. Briefly, the Regional Health Authorities Act (1994) was assented to in June of 1994; it divides the health care system of Alberta into 17 geographic regions. These regions replace over 200 separate boards for hospitals, health units and other health service institutions. The Act sets out five key responsibilities for the newly established regional health authorities which shall:

- promote and protect the health of the population in the health region and work towards the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate health resources accordingly;
- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to individuals and communities and supports the integration of services and facilities in the health region.

Two additional province-wide "regions" have been identified to provide leadership and expertise for cancer and mental health services. Since the establishment of the regions, the role of the provincial Department of Health and Wellness has been shifting to one of advice and support to, as well as monitoring of, the regional boards and their authorities. Although the mandate for health promotion that is explicated in the Act is of the most immediate relevance for our examination of "New Spaces for Health Promotion," the greater integration of health care services that is an implicit outcome of the Act is also relevant as are the espoused policy goals of this integration. Alberta Health and Wellness has identified a set of health goals for Alberta; several relate to health promotion and disease prevention:

- To increase the number of years of good health by reducing illnesses, injuries and premature deaths and improving well-being;

- To live in strong, supportive and healthy families and communities;
- To live in a healthy environment;
- To choose healthy behaviours; and
- To develop and maintain skills for facing the challenges of life in a healthy way.

The Alberta research site, Calgary and its surrounding metropolitan area, encompasses over 900,000 residents. The municipal political boundaries virtually coincide with the boundaries of the Calgary Regional Health Authority (CRHA), which is the monopoly provider of hospitals and acute-care services.[5] The Regional Health Authority Act (1994) delegates responsibility for the protection of health and provision of health care for the entire regional population to the regional health authority. In addition, the CRHA has a number of specialist services that are available province wide. Almost all residents are also covered by Alberta Health Care, which provides publicly funded and universal health care coverage.

The American Context

Even though American-Canadian comparisons are rare in the health policy literature, American policy makers have been taking cues from the Canadian experience since the 1970s. During the 1970s, rising costs of health care became an important concern in the United States, and political leaders thought they might benefit from a strategy of health promotion (Leichter, 1991). Just two years after the Canadian Lalonde Report, Congress enacted the National Consumer Health Information and Health Promotion Act. The following were the key provisions of this law (Public Law 94-317):

- develop a strategy of health education and promotion that might include research, information, and training programs, and granting funds to private, non-profit organizations working in the area of health promotion;
- conduct periodic surveys of the health care needs and knowledge of Americans;
- report to Congress within two years on health promotion activities;
- determine the extent to which health insurance programs cover health promotion and education services; and
- establish an Office of Health Information and Health Promotion to help coordinate these related activities.[6]

The Surgeon General's 1979 report on health promotion, which put health promotion on the political agenda, was a "direct outgrowth" of the 1976 Act. The document was entitled Healthy People and, according to the then Secretary of Health, Education and Welfare, Joseph Califano, represented, "an emerging consensus among scientists and the health community that the Nation's health strategy must be dramatically recast to emphasize the prevention of disease..." (Public Health Service, 1979:vii).

The report was followed in 1980 by the United States Public Health Service's Promoting Health/Preventing Disease: Objectives for the Nation. It included 226 objectives and articulated a "new consensus" regarding environmental health hazards. In 1986, the Public Health Service held a "mid-course review" to determine if the 226 objectives would be achieved and how best to proceed, given the mid-point successes and failures. That same year, the United States government published major studies under the health promotion umbrella: (1) the Surgeon General's Report on

Smoking and Health, which called for a smoke-free society by the year 2000; and (2) publications on AIDS. In July 1988, the first national Report on Nutrition and Health was published. Moreover, since the 1980s, the federal government has made available Health Block Grants which provide for programs at the federal, state and local levels through initiatives by the Centers for Disease Control, the United States Department of Agriculture, the Occupational Safety and Health Administration, and the Environmental Protection Agency, to name only a few.

Healthy People 2000 is the next ten-year effort that follows Healthy People. It is coordinated by the Department of Health and Human Services but is seen by the federal government as a much broader document. The authors of the report note that the objectives are "national as distinct from Federal.... They are meant to reflect the potential accomplishments of improvements sponsored at every level and in many sectors" (United States Department of Health and Human Services, 1990:90). This distinction suggests that the document is intended to foster partnerships at all levels. Some of the Healthy People 2000 objectives are directed at HMOs. For example, Objective 8.12 is: "Increase to at least 90 percent the proportion of hospitals, health maintenance organizations, and large group practices that provide patient education programs, and to at least 90 percent the proportion of community hospitals that offer community health promotion programs addressing the priority needs of their communities" (United States Department of Health and Human Services, 1990:620).

The California Context

In California, the Office of County Health Services (OCHS) administers the Health Incentive Program (HIP) which provides funding at the local level for disease prevention and health promotion in priority areas designated by Healthy People 2000. Priorities are defined for each fiscal year from 22 possible areas. The Office of County Health Services also administers the Proposition 99 Contract Back Programs which provide reimbursement to health care providers for poor adults and children in small rural counties. The OCHS primarily gives funding for health promotion programs that raise awareness.

California has been a leader in the tobacco strategy with the passage, via referendum, of Proposition 99 – The Tobacco Tax and Health Protection Act of 1988. The resulting revenues from tobacco taxation have opened up opportunities for cessation programs and initiatives to denormalize tobacco use as well as a variety of other activities.

Another major actor at the state level is the Prevention Services of the California Department of Health Services. Its mission is "to prevent disease and premature death and to enhance the health and well-being of all Californians." Prevention Services is involved in all aspects of health promotion. There are nine divisions of Preventive Services:

- Division of Chronic Disease and Injury Control;
- Division of Communicable Disease Control;
- Division of Drinking Water and Environmental Management;
- Division of Environ and Occupational Disease Control;
- Division of Food, Drug and Radiation Safety;
- Laboratory Science;

- Office of Border Health;
- Office of Clinical Preventive Medicine; and
- Office of AIDS.

Managed care was introduced in San Diego County in 1947. In that year, Dr. Charles Stevenson, a surgeon, started a prepaid medical care agency fund called San Diego Health Association, the insurance arm of which was called "The Complete Service Bureau." In 1967, the San Diego Health Association went bankrupt and was sold to Kaiser Permanente, then with a 22,000 member base. The San Diego Health Association was unusual in that it introduced an advanced idea into a very conservative community. There are currently four major managed care organizations operating in the County: Kaiser-Permanente (non-profit); Scripps (ScrippsHealth – non-profit; ScrippsClinic – for-profit); SHARP (non-profit); and UCSD (non-profit). In addition, there are numerous other managed care providers including Community Health Group (CHG), which is the managed care plan (MCP) for community hospitals. Thus there are non-profit, community and for-profit providers in San Diego. Currently, San Diego County encompasses approximately three million residents; it is a very loosely articulated political system that does not have a corresponding health care or health delivery system. Therefore to speak of the San Diego "health care system" is only to speak of that large group of largely autonomous health care players who operate within the geographic confines of San Diego County.

The Comparative Context

Moving beyond vision embedded in legislative mandates, policies and statements of principle, the understanding of change strategies and indicators for health outcomes remains scarce and illusive. Change for the sake of change is no longer (and probably never was) affordable. Health policies and practices focused on disease prevention and health promotion require change strategies linking the effectiveness of health care delivery to health gain (improving health) or at least health maintenance.

The espoused intent of at least some health policy in both Canada and the United States is aimed at transforming health care delivery in order to influence health status alongside achieving the best use of limited resources. Presenting and discussing some of the programs in place for the prevention of disease and the promotion of health on both sides of the border may help us "push the boundaries" of good practice. Recognizing the different contexts for health promotion and disease prevention within the jurisdictions studied should help delineate the potential opportunities for shared learning as well as the structural and/or cultural barriers to shared learning.

NOTES

1. Managed care can be defined as "a type of prepaid health plan or insurance program in which the enrollees receive medical service in a coordinated manner to eliminate unnecessary services.... There are a variety of managed care programs ranging from health maintenance organizations (HMOs) and preferred provider organizations (PPOs) to preadmission reviews required by some traditional health insurance companies. All have a common goal: to reduce health care expenditures while maintaining the quality of care" (Raffel and Raffel, 1989:75). Concepts associated with managed care (Vinicor, 1998:87) include: (1) accountability (Inglehart, 1996); (2) shared financial risk (Bodenheimer and Grumbach, 1996); (3) evidence-based guidelines; and (4) population-based medicine.

2. There are wide ranging understandings and perspectives on what constitutes a "regionalized" system of health care. Regionalization is usually described in part or whole as being about reorganizing or reorienting or refocusing the health care system in the context of either a centralized or decentralized budget, and involving a focus on geography, or relating a health system to defined populations. See Lomas, Woods and Veenstra (1997).

3. Other components of quality of care identified by Lamb et al. (1991) are: continuity of care, coordination of care, technical quality of care, enhanced access to care, and enhanced use of multidisciplinary teams.

4. The following organizations are members of CHIP: Alliance Healthcare Foundation; Children's Hospital and Health Center; Combined Health Agencies; Community Health Group; Council of Community Clinics; County of San Diego Department of Health and Human Services; EdVantage, UCSD Office; Healthcare Association of San Diego and Imperial Counties; Kaiser Permanente; Mercy Hospital of ScrippsHealth; Mesa Vista Hospital; Naval Medical Center; Palomar Pomerado Health System; Paradise Valley Hospital; San Diego County Medical Society; San Diego Hospice; San Diego State University Graduate School of Public Health; ScrippsHealth; SHARP Health Plan; SHARP HealthCare; Tri-City Medical Center; UCSD Medical Center; UCSD School of Medicine; United Way of San Diego County; Veterans Administration; Vfilla View Community Hospital; and Vista Hill Foundation.

5. The municipal and CRHA boundaries do not perfectly coincide. All of Calgary falls within the territorial boundaries of the CRHA, but the latter extend to include bedroom and satellite communities outside of Calgary: Airdrie, Balzac, Beiseker, Billhart, Bragg Creek, Chestermere Lake, Cochrane, Collicut, Conrich, Crossfield, Dalemead, Delacour, Ghost Lake, Indus, Irricana, Janet, Kathryn, Keoma, Langdon, Madden, Norfolk, and Shepherd.

6. This was later named the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine.

REFERENCES

Abelson, Julia and Jonathan Lomas. (1990). "Do Health Service Organizations and Community Health Centres Have Higher Disease Prevention and Health Promotion Levels than Fee-for-Service Practices?" *Canadian Medical Association Journal* 142 (6), pp. 575-581.

Bella, L. (1981). *The Politics of the Right-Wing "Welfare State."* Doctoral Dissertation, University of Alberta, Edmonton.

Berlin, S. (1990). "Current Status and Indicator Needs of the Canadian Healthy Communities Project" in J. Feather and B. Mathur, eds., *Proceedings of an Invitational Workshop: Indicators for Healthy Communities.* Winnipeg: Prairie Region Network on Health Promotion Knowledge Development.

Bodenheimer, T. S. and K. Grumbach. (1995). *Understanding Health Policy: A Clinical Approach.* Norwalk, CT: Appleton and Lange.

Brook, R. H., E. A. McGlynn and P. D. Cleary. (1996). "Quality of Health Care. Part 2: Measuring Quality of Care." *New England Journal of Medicine* 335, pp. 966-9.

Bryson, J. M. (1988). *Strategic Planning for Public Nonprofit Organizations: A Guide to Strengthening Organizational Achievement.* San Francisco: Jossey-Bass Publishers.

Carlaw, Raymond W. and Nina M. DiAngelis. (1982). "Promoting Health and Preventing Disease – Some Thoughts for HMOs." *Health Education Quarterly* 9 (1), pp. 81-95.

Casebeer, Ann and Kathryn Hannah. (1998). "The Process of Change Related to Health Policy Shift: Reforming a Health Care System." *International Journal of Public Sector Management* 11 (7), pp. 566-582.

Casebeer, Ann, Cathie Scott and Kathryn Hannah. (1998). *Towards a Strategy for Community Based Care: Managing Community Shift Within a Newly Regionalized System of Care.* Calgary: Department of Community Health Sciences, University of Calgary.

Casebeer, Ann and W. Thurston. (1995). "Evaluability Assessment in Health Care: An Example of the Patient Care and Outcome Process." *Canadian Journal of Program Evaluation* 10 (1), pp. 89-102.

Cowley, James. (1986). "When Health Promotion Works, the Opposition Begins: A Personal View." *Health Promotion* 1 (2), pp. 201-209.

Crawford, R. (1977). "You are Dangerous to your Health: The Ideology and Politics of Victim Blaming." *International Journal of Health Services* 7, pp. 663-680.

Epp, J. (1986). *Achieving Health for All: A Framework for Health Promotion.* Ottawa: Health and Welfare Canada.

Frankish, C. James et. al. (1996). *Health Impact Assessment as a Tool for Population Health Promotion and Public Policy.* Vancouver: Institute of Health Promotion Research, University of British Columbia.

Friedmann, J. (1987). *Planning in the Public Domain: From Knowledge to Action.* Princeton: Princeton University Press.

Harris, Jeffrey R., Blake Caldwell and Kathy Cahill. (1998). "Measuring the Public's Health in an Era of Accountability: Lessons from HEDIS." *American Journal of Preventive Medicine* 14 (3S), pp. 9-13.

Health Canada. (1996). *Provincial Health System Reform in Canada: Update 1996.*

The Health Care System in Canada and its Funding: No Easy Solutions. (1991). Ottawa: House of Commons.

Iglehart, J. K. (1996). "The National Committee for Quality Assurance." *New England Journal of Medicine* 335, pp. 995-9.

Kotani, Nancy and Ann Goldblatt. (1994). "Alberta: A Haven for Health Promotion" in Pederson A., M. O'Neill and I. Rootman, eds. *Health Promotion in Canada.* Toronto: W.B. Saunders.

Kouri, D., J. Dutchak and S. Lewis. (1997). *Regionalization at Age Five: Views of Saskatchewan Health Care Decision-Makers.* HEALNet (Health Evidence Application and Linkage Network).

Labonte, Ronald. (1996). "The Population Health/Health Promotion Debate in Canada: The Politics of Explanation, Economics and Action."

Lalonde, M. (1974). *A New Perspective on the Health of Canadians.* Ottawa: Health and Welfare Canada.

Lamb, Marianne, Raisa Deber, C. David Naylor and John E. F. Hastings. (1991). *Managed Care in Canada: The Toronto Hospital's Proposed Comprehensive Health Organization.* Ottawa: Canadian Hospital Association Press.

Leichter, Howard M. (1991). "Free to be Foolish: Politics and Health Promotion in the United States and Great Britain." New Jersey: Princeton.

Lomas, Jonathan, John Woods and Gerry Veenstra. (1997). "Devolving Authority for Health Care in Canada's Provinces." *Canadian Medical Association Journal* 156 (3), pp. 371-377.

Luft, Harold S. (1978). "Why Do HMOs Seem to Provide More Health Maintenance Services?" *Health and Society* 56 (2), pp. 140-167.

Marmor, Theodore. (1993). "Commentary on Canadian Health Insurance: Lessons for the United States." *International Journal of Health Services* 23 (1), pp. 45-62.

Mhatre, S.L. and R. B. Deber. (1992). "From Equal Access to Health Care to Equitable Access to Health: a Review of Canadian Provincial Health Commissions and Reports." *International Journal of Health Services* 22 (4), pp. 645-666.

Milio, N. (1988). "Strategies for Health-promoting Policy: a Study of Four National Case Studies." *Health Promotion* 3 (3), pp. 307-311.

Mullen, Patricia Dolan and Jane G. Zapka (1981). "Health Education and Promotion in HMOs: The Recent Evidence." *Health Education Quarterly* 8 (4), pp. 292-315.

National Forum. (1997). *Canada Health Action: Building on a Legacy.* Health Canada.

O'Donnell, Michael P. (1986). "Definition of Health Promotion." *American Journal of Health Promotion* Summer 1986, pp. 4-5.

Public Health Service. (1979). *Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention.* Washington, DC: United States Department of Health and Human Services.

Raffel, Marshall W. and Norma W. Raffel. (1989). *The U.S. Health System: Origins and Functions.* New York: Harwal Publishing.

Roemer, Milton I. (1991). "Prudence in International Comparisons: Insights for the United States from the Canadian Health Insurance Experience." *International Journal of Health Services,* 21 (4), pp. 681-684.

Rootman I. and J. Raeburn. (1994). "The Concept of Health" in Pederson A., M. O'Neill and I. Rootman, eds. *Health Promotion in Canada.* Toronto: W.B. Saunders.

Rutherford, George W. (1998). "Public Health, Communicable Diseases, and Managed Care." *American Journal of Preventive Medicine* 14 (3S), pp. 53-59.

Siler-Wells, G. I. (1988). *Directing Change and Changing Direction: A New Policy Agenda for Canada.* Ottawa: Canadian Public Health Association.

Smith, Mark. (1998). "Opening Plenary." *American Journal of Preventive Medicine* 14 (3S), pp. 4-6.

Taras, Howard L. (1997). "Managed Health Care and School Health." *Pediatric Annals* 26 (12), pp. 733-736.

United States Department of Health and Human Services. (1990). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.*

Vinicor, Frank. (1998). "Diabetes Mellitus and Asthma: 'Twin' Challenges for Public Health and Managed Care Systems." *American Journal of Preventive Medicine* 14 (3S), pp. 87-92.

Vogt, Thomas M., Neal D. Kohatsu and George W. Rutherford. (1994). "Prevention in Managed Care." *Epitomes – Preventive Medicine and Public Health* 161 (1), pp. 63-64.

Weiss K., P. Gergen and T. Hodgson. (1992). "An Economic Evaluation of Asthma in the United States." *New England Journal of Medicine* 326, pp. 862-866.